Anti-Fraud Plan

In meeting client expectations compliant to appropriate state regulations, ValueOptions, Inc. submits the following Anti-Fraud Plan and Special Investigations Unit descriptions. This plan sets forth specific instructions to detect, investigate and report insurance fraud, including, but not limited to internal fraud, all lines claim fraud, health care fraud, application and underwriting fraud.

ValueOptions pays for mental health services for millions of members and makes payments to tens of thousands of mental health providers. As such, this provides ample potential for improper billing, whether erroneous or fraudulent in nature. ValueOptions has a department, the Special Investigations Unit (or SIU), responsible for reviewing and monitoring claims and billings by providers to ensure payment has been properly requested and made.

ValueOptions has four primary divisions: Employer Solutions (Employer groups), Health Plan (Public and Private Groups, insurance company carve-outs), Public Sector (Medicaid) and Federal Services (Tricare). All of these are subject to scrutiny by ValueOptions SIU and regulatory authorities responsible for monitoring health insurance fraud and abuse activity. Provisions in both the Balanced Budget Act of 1997 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) make it very evident that federal lawmakers are intent on addressing issues of fraud and abuse. Within the industry the Centers for Medicare and Medicaid Services (CMS), the Department of Health and Human Services Offices of the Inspector General (HHS-OIG), the FBI, and the United States Attorney's Offices, have joined forces to administer a comprehensive anti-fraud program. In addition state insurance laws and enforcement authorities have focused considerable effort on improper billing and fraud. ValueOptions, Inc. adheres to all Federal and State laws that regulate, enforce and sanction fraud and abuse activities.

The components of ValueOptions' Anti-Fraud plan are as follows:

I. Education and Training

II. Detection and Investigation of Insurance Fraud

III. Reporting Insurance Fraud

IV. Anti-Fraud Organizations

V. Chart of Organization Arrangement of Personnel

Definitions

1. FRAUD:
   a. Intentional deception or misrepresentation made by an entity or person in any managed care setting with the knowledge that the deception could result in some unauthorized benefit to the entity, himself/herself, or some other person.
   b. In the context of health care claims, purposely billing for services that were never rendered, for a service that has a higher reimbursement than the service provided, or at the incorrect reimbursement level.
2. ABUSE:
   a. Practices in any managed care setting that are inconsistent with sound fiscal, business, or medical practices and which result in an unnecessary cost to a government health care program or other health care plan.
   c. Practices that result in reimbursement for services or products that are not medically necessary or that do not meet professionally recognized standards for health care.

I. FRAUD AND ABUSE TRAINING PROGRAM

The Special Investigations Unit has the general responsibility to oversee the development, implementation and periodic distribution of employee communications and training programs relevant to Fraud and Abuse. Review of state and federal guidelines pertaining to fraud and abuse statutes.

A. All Employees Fraud and Abuse training includes the following;

1. New employees must complete the online Fraud & Abuse training as part of the new hire process within the first 90 days of employment; VONM new employees within the first 30-days.
2. **A**nnual review of online training module and corporate policy S103, and VONM policy CMP503 to ensure successful completion for all employees.
3. All ValueOptions' employees are required to review and successfully pass the Fraud & Abuse online training via Staff Connect before signing the 'Annual Attestation Sheet'. The Certificate of Completion for Fraud & Abuse must be attached and sent to the Human Resource Department.
4. Online training provides a general overview of Fraud & Abuse regulations and related policies and procedures for reporting. This fulfills the requirements as stipulated by the Deficit Reduction Act (DRA), which was effective as of February 1st, 2007.

B. Special Investigations Unit staff:

1. Orientation:
   a. All new Investigators, prior to handling cases independently, will conduct initial investigations conjointly with an experienced investigator or management. This will continue at the discretion of management.
   b. Investigators will be required to receive training on ValueOptions claims processing systems, documentations systems, and documentation storage systems.
2. External Training:
   a. SIU staff will be offered periodic training through NHCAA organization including monthly telephonic training seminars, Regional Training Seminars, and Annual Training Conferences (ATC) as appropriate.

II. PROCEDURES FOR DETECTION AND INVESTIGATION OF INSURANCE FRAUD

A. Detection:

1. ValueOptions employs a process for detection, referral, investigation, and action plan detailed in Special Investigations Unit (SIU) Policy number S103 titled Health Care Claims Fraud and Abuse Investigations and VONM policy number CMP503 also titled; Health Care Claims Fraud and Abuse Investigations.
2. Opportunities for detecting fraud may be identified through the following means:
   a. Employee Training
   b. Claims submitted for payment;

(ValueOptions, Inc. (CAS) system is configured per state contract to flag claims during adjudication such as; possible duplicate claims, timely filing limits, services not authorized, authorized units exceeded, member not eligible, etc.

c. Quality/Clinical Referrals
d. Paid claims report
e. Provider/Member Complaints
f. Onsite provider audits
g. Compliance Officer Referral
h. Customer Service Referral
i. SIU Inquiry
j. VONM E-mail address
k. Reports to the Ethics Hotline
l. Other sources (e.g. external referral NHCAA, NCC, OIG, state, etc)

3. ValueOptions Compliance Department regulates policy number LC3.09P focusing on the issue of False Claims.
4. ValueOptions SIU examines and identifies billing trends through a set of reporting tools. These "data mining" tools include biweekly, monthly, and early reports (for internal use only) examining:
   a. High Volume of Sessions,
   b. High Volume of Dollars Paid,
   c. Family Groupings of Sessions,
5. High Volumes of unduplicated enrollees reports (high quantity of patients),
6. Duplicate claim submission, and Matching Surnames (Providers and Members with matching surnames).

B. Referrals/Inquiries

1. The identifying staff member refers potential cases to the SIU inquiry queue VOFIQFAB to include complaint specifics. Exception: if the inquiry/referral is associated with the state of Texas, the staff member will forward to the SIU inquiry queue noted above within twenty-four (24 hours) from the receipt of allegation. Exception: If associated with VONM, cases should be referred to e-mail address; VONMFraudandAbuse@ValueOptions.com
2. If the identifying staff member feels that the matter requires immediate review/action and following the submission of the above notification process, the staff member can contact the Director of SIU directly via e-mail or telephone.
3. If the referral/inquiry submitted to SIU suggests; harm or death to patients or another grieves quality of care issue, SIU will *expedite* the referral to our internal Clinical and other appropriate sources (i.e. Compliance, Netops for immediate suspension of referrals, etc.

C. SIU Initial Review

1. Evaluation of the reason for referral; Exception: If associated with the state of Texas, the initial review will occur within 15-days from

receipt of notification.

2. Evaluation of any supporting documentation;
3. Review of historical data for previous referrals/investigations, for similar reasons tied to same provider/member.
4. Evaluation of the potential magnitude of the problem to include; whether education was previously provided specific to the allegation filed.
5. Review with other appropriate internal resources;
6. All cases involving internal staff are reviewed with Human Resources;
7. If the investigation does not support the allegations of fraud or abuse, the findings are documented in the SIU database and the issue is closed.
8. If the initial review suggests potential fraudulent and/or abusive billing practices, SIU will open case.
9. Results of SIU referrals will be made available upon request.
10. Investigator will assign a case number for tracking purposes by entering all data associated with the initial referral and/or notification into SIU database.
11. SIU reporting available upon request during normal business hours EST.
12. The investigator assigned the case, will run a query from claims system CAS to capture all claims processed specific to date span (e.g., 1/1/02 through current date)

D Investigation

1. Claims Billing Audits:
   a. Review of provider or facility treatment records for comparison with claims (electronic or paper) submitted to determine accuracy of services billed for reimbursement.
   b. ValueOptions conducts claims billing audits in two ways:
      i. In-house record review requests
      ii. On-site Audits

2. Randomly select the greater of 5% or five (5) members or 100% of member volume if fewer than five (5) members treated by the provider under investigation from the queried claims information, and request documentation required. Exception: If associated with the state of Texas, the random selection process will occur within 15 working days from the conclusion of the preliminary review.

3. SIU will send record request to the provider, and attach a listing of requested member information to include; member name, member number, and member DOB for provider reference. Exception: If associated with the state of Texas the request will be sent within 15 working days from the random selection.

   a. Providers must supply copies of requested records ValueOptions within the time notated via record request letter. The allotted

time in which to return records can vary and is based on the number of records SIU requests. For example:
1 – 49 equal (10) days
50 – 199 equal forty five (45) days
200 or greater equal sixty (60) days
Providers can request an extension by contacting SIU prior to the due date communicated via request letter mailed.

4. The Special Investigator establishes an investigation team, which may consist of one or more of the following departments:
   a. Claims Department for coding issues or irregularities in claims submissions;
   b. Clinical Operations Department for review of unusual or questionable practice patterns;
   c. Provider Relations Department and Network Operations for provider credentialing or communications issues;
   d. Finance Department for information about actual payments made to providers;
   e. Compliance Department for consultation on regulatory and contractual issues;
   f. Legal Department for legal issues;
   g. Human Resources for management of cases involving internal staff.
5. The SIU coordinates actions of all departments involved in the investigation, including:
   a. Identification, request, review and storage of pertinent documents,
   b. Retrieval and analysis of claims, clinical data, contractual, and provider information from ValueOptions systems,
   c. Requests for additional information from practitioner including but not limited to patient records, and payment reconciliation data,
   d. Completion of claims billing audits.
6. If the investigation supports fraudulent and/or suspicious billing patterns corrective actions are required and may include;
   a. Identification of inappropriate claims payments
   b. Notification to a provider of Monitoring Plan
   c. Requirement of Corrective Action Plan (CAP)
   d. Recommendation for Provider Education
   e. Updates to key management staff
   f. Documentation of findings at the conclusion of the investigation
   g. Confirmation that corrective actions are completed
7. If the investigation does not support the allegations filed, the case findings will be documented via database for tracking/reporting purposes and future reference, and then closed.
8. All detailed information about the investigation is recorded in a separate and secure record accessible only to the SIU and Legal Departments and is bound by the Health Insurance Portability and Accountability Act (HIPAA), **45 CFR, Title II, §201-250.**

E. Action Plan

1. The SIU coordinates with providers to develop and implement one or more of the following as part of the Action Plans:
   a. SIU to recover overpayments.
   b. Provider submission of a detailed Corrective Action Plan (CAP).
   c. SIU maintained Monitoring Program. The monitoring program may be for a six (6) month or twelve (12) month time period, as determined by the Director of the SIU, and involves additional claims billing audits to ensure adherence to the submitted CAP.
   d. SIU and Provider Relations to collectively conduct provider education to disciplined practitioner or facility.
2. If compliance with our Claims Billing Audit process is not met, one or more of the following actions will be taken:
   a) Recoupment of funds tied to the date span audited (e.g. 24 month period).
   b) National Credentialing Committee to report findings to credentialing, licensing, and public bodies and to review participation in ValueOptions networks.
   c) Legal for review of legal issues (e.g. Provider request unique requests, terminally ill, etc).
   d) Network Operations and/or Eligibility are notified for flagging provider or member records in the claims system(s).
   e) Human Resources to manage disciplinary process when internal staff is involved.
   f) All Texas providers that do not comply with an SIU claims billing audit will be reported to the HHSC-OIG

III. REPORTING INSURANCE FRAUD

A. Network Termination- when our network providers do not resolve issues of abusive or inappropriate billings, ValueOptions will recommend to the NCC immediate termination of said provider from our networks.

B. State and/or Federal Referral*:* ValueOptions will report any suspicion or knowledge of fraud and/or abuse that requires an external investigation to the appropriate authorities. Exception: All allegations submitted to SIU that are associated with the state of Texas will be reported to; ValueOptions Service Center and Corporate Compliance Officers within 15-days from date of notification to SIU. The Service Center Compliance Officers are responsible to forward this information to the HHSC-OIG within 30-days from receipt.

C. Exception: For the state of Texas, SIU will provide to the Service Center Compliance Officer a report listing all investigations conducted that result in no findings of waste, abuse or fraud. The report shall include; the allegation, the suspected recipients or providers Medicaid/CHIP number, the source, the time period in question and the date of receipt of the identification and/or reporting of suspected and/or potential waste, abuse and fraud conducted by ValueOptions Corporate Special Investigations Unit (SIU).

D. ValueOptions will cooperate fully in any investigation or subsequent legal action

that may result from such an investigation. ValueOptions and its providers are required to make available to investigators any administrative, financial, and medical records such investigators may require.

IV. MEDICAL RECORD RETENTION AND/OR DESTRUCTION:

1. SIU will destroy documentation submitted by the providers to support billings to ValueOptions under review if there is no billing discrepancies/errors revealed during the investigation.
2. SIU will maintain documentation submitted by providers to support billings to ValueOptions if there is any billing discrepancies/errors revealed during the investigation. This documentation will be maintained in the SIU paper case file.
3. All records will be maintained according to the Corporate Record Retention Policy for the time period specified for SIU records.

V. ANTI FRAUD ORGANIZATIONS

A. ValueOptions maintains corporate membership with the aforementioned NHCAA.

VI. CHART OUTLINING ORGANIZATION ARRANGEMENT OF PERSONNEL

A. (Attach Corporate SIU Chart here)

B. See individual Service Centers for Department Organization and policy exceptions